STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNSTER MED-INN	7935 CALUMET AVENUE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00090194 and IN00090614. Complaint IN00090194 substantiated, no deficiencies related to the allegations are cited. Complaint IN00090614 unsubstantiated, due to lack of evidence. Unrelated deficiencies cited. Survey dates: May 31 and June 1, 2011 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Survey team: Janelyn Kulik, RN, TC (June 1, 2011) Heather Tuttle, RN Census bed type: SNF: 19 SNF/NF: 175 Total: 194 Census payor type: Medicare: 37 Medicaid: 124 Other: 33	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Total: 194 Sample: 11 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/5/11 Cathy Emswiller RN			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure every resident was free from abuse related to a witnessed allegation of physical abuse for 1 of 3 allegations of abuse reviewed. (Resident #D) Findings include: The allegation of physical abuse was reviewed on 6/1/11 at 1:45 p.m. Review of the Memorandum provided by the facility indicated on 5/20/11 at 3:30 p.m., LPN #1 was seated at the nurse's station with Resident #D sitting a wheelchair	F0223	**F-223** Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of Kim Rhoades, Director of Long Term Care, letter to this facility dated June 6, 2011, the facility offers the following: **1. What corrective action(s) will**	07/01/2011

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	seated next to her. LPN #1 indicated the resident was observed to be leaning forward in her wheelchair, which had been typical for this resident despite staff's attempts to reposition her. LPN #2 was observed to approach Resident #D from behind and roughly pull her body forward in the wheelchair and then roughly push the resident's wheelchair forward up to the nurse's station. LPN #1 indicated LPN #2 did not make any attempts to notify the resident of her intended actions. LPN #1 also indicated that CNA #1 was also sitting at the nurse's station at that time, and witnessed the entire event. Review of the witness statement provided by LPN #1 dated 5/20/11 indicated "At approximately 3:30 p.m., I was sitting at the nurse's station on the second floor. Resident #D (name) was also sitting at the nurse's station. She was bent over in her wheelchair, which is not abnormal for her. LPN #2, who was assigned to the second floor unit walked up behind Resident #D and using the resident's shoulder roughly pulled her up to a sitting position in the wheelchair and shoved the chair under the counter of the nurse's station and locked the brakes. LPN #2 angerly stated she was sick and tired of cleaning up everyone's mess." Review of the witness statement provided		**be accomplished for those residents found to have been affected by the deficient practice?** As it relates to the resident identified as Letter D, we respectfully offer that immediately upon receipt of the concern of possible abuse, the facility removed LPN#2 from the nursing unit and commenced an investigation. In accordance with the Indiana State Department of Health guidelines for Reportable Occurrences and facility policy and procedure, we reported the allegation of possible abuse. Additionally, prior to surveyor citation, the facility submitted a final report indicating the outcome of our investigation and corrective actions taken. LPN#2 subsequently resigned from her employment with our facility which was noted in the facility's final report. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Munster Med-Inn is committed to investigating all allegations of abuse and reporting as such in accordance with the Indiana State Department of Health and facility policy and procedure. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** We respectfully offer that	

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	by CNA #1 (no date) indicated "I worked the second floor unit on 3-11 shift on 5/20/11. I observed Resident #D sitting at the nurse's station. LPN #2 came up behind the resident, put her hand on her chest and jerked her to a sitting position. She then shoved her wheelchair under the counter and locked the brakes. LPN #2 then instructed the me to check to see if she was wet. LPN #2 was abrupt and rough with Resident #D. LPN #2 did not have any conversation with the resident prior to moving her...." Further review of the allegation of abuse indicated upon receipt of the concern, LPN #2 was immediately removed from the facility pending the initiation of the investigation. Interview with LPN #1 on 5/31/11 at 2:00 p.m., indicated she did witness the entire event that happened on 5/20/11. She indicated LPN #2 came up from behind the resident, grab her and roughly pushed her back into the wheelchair. She also indicated the LPN pushed her wheelchair under the nursing station counter and locked the brakes. LPN #1 indicated that she reported the incident to the Director of Nursing immediately. 3.1-27(a)(1)		the below noted corrective actions were taken as a direct result of our initial investigation at the time of the occurrence. In response to the allegation of abuse involving the Resident D, the facility provided an in-service on June 1, 2011 to all staff on the provision of care to cognitively impaired residents with a focus on proper approach. As a facility, we are fully committed to on-going in-service education and present Resident Abuse and Abuse Prevention topics on a minimum of a quarterly basis. In addition to our previously implemented corrective action, the facility is committed to presenting a mandatory in-service on the topic of Possible Resident Abuse/Reporting of Possible Abuse for all-staff through our on-going In-Service Education Program. This in-service will be presented prior to July 1, 2011. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The facility has a comprehensive Abuse Prevention Policy in place which is reviewed annually. We are committed reviewing our policies and making any necessary revisions or updates as needed during the annual review process or at any other time deemed appropriate. In addition, the facility offers that through our Quality Assurance	

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			Program/Manager of The Weekend Focus Program, an audit of Abuse Protocols is completed. The audit is performed on a quarterly basis and requires that random sample of staff across all departments be interviewed to ensure they are aware of the various types of abuse, how to report abuse, and to whom reports should be made. The findings from these audits are compiled by facility Administrator and reported to the Quality Assurance Committee on a quarterly basis. **5. By what date the systematic changes will be completed?** July 1, 2011	

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure every suspected allegation of abuse was reported promptly to the Administrator for 1 of 3 allegations of abuse reviewed, as well as obtaining	F0225	**F-225** Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of	07/01/2011

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	references for 4 of 5 newly hired employees in a sample of 5 newly hired employees. (Resident #L, CNA #2, CNA #3, CNA #4, and Laundry #1) Findings include: 1. Review of the Memorandum dated 12/13/11 of an allegation of abuse towards residents on the fifth floor indicated the facility had received an anonymous letter indicating the Unit Manager had been abusive toward some of the residents. Review of the anonymous letter dated 11/19/10 received by the facility 11/30/10 indicated the person writing the letter was a concerned family member with family who resided on the fifth floor. The family member indicated they visit their loved one several times a week and felt obligated to inform the facility of the things they had seen and heard from the Unit Manager towards some of the residents. The family member alleged the Unit Manager was rough with the residents and pushed them down. On one occasion they had seen her push a resident back down in their seat and say in a harsh voice, "sit your a** down." They had also heard her say to a resident she was fu***** sick and tired of a resident who was somewhat agitated and would be glad when she shut the he** up. On another		this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of Kim Rhoades, Director of Long Term Care, letter to this facility dated June 6, 2011, the facility offers the following: **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility took a number of corrective actions as a result of our original investigation into this matter. To recount those corrective actions previously communicated in our final report dated December 13, 2010, the facility conducted Stress Management and Abuse Prevention in-servicing to all staff. This in-service covered the topic of stress management as well as the expectations of reporting all possible abuse in a timely manner. As it relates to C.N.A. #2, C.N.A. #3, C.N.A. #4, and Laundry #1, the facility has completed reference checks and they are currently in place in the identified staff member's personnel files. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	

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	occasion the family member had witnessed a CNA trying to calm a resident down and was not successful. The Unit Manager indicated that she was going to give her something that would shut her fu***** trap for the rest of her shift. Continued review of Memorandum dated 12/13/11 indicated upon receipt of the letter the Unit Manager was immediately removed from her position and was placed on administrative leave pending the outcome of the investigation. The facility was then able to speak personally to 26 family members. The facility indicated there was mostly positive feedback, but one family member verbalized the Unit Manager had a bad attitude and she was described as being insensitive. The facility also spoke to 6 professionals who routinely work with the Unit Manager on the fifth floor. The facility indicated some of the staff felt that the Unit Manager was compassionate and others felt she was not. Some staff indicated she had a "rough" way about her. Most staff felt the Unit Manager became frustrated easily and that caused a negative interaction with staff but not the residents. All of the staff had indicated they had never seen the Unit Manager use profanity in front of the residents or was physically abusive towards them.		**action(s) will be taken?** As it relates to the resident identified as Resident L, the facility takes a very strong position with regard to timely reporting of possible abuse. The facility will, in the future, provide appropriate corrective action (including discipline if deemed appropriate) for any staff member who does not report possible abuse in a timely manner. In an effort to offer additional corrective action as a part of this plan of correction, the facility will present follow-up in-servicing on the topic of Stress Management and Abuse Prevention in-servicing to all staff which will include requirements for timely reporting of possible abuse. As it relates to the completion of reference checks for new employees, the facility is committed to reviewing the personnel files of all newly hired staff in the past 120 days to verify the presence of a completed reference check. Any identified personnel files lacking a reference check will have one completed via telephone. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** As it relates to the resident identified as Resident L, the facility will continue to provide on-going in-service education to all staff on the policies for timely reporting of possible abuse. Through our	

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	Review of LPN #3's statement dated 12/1/10 regarding the Unit Manager from the fifth floor indicated the LPN had worked three days a week and had the occasion to work with the Unit Manager. She indicated there had been occasions when the Unit Manager had been potentially abusive towards a resident. LPN #3 had observed poor interactions with Resident #L and that the Unit Manager had been forceful in making Resident L sit down when standing. LPN #3 had also observed the Unit Manager mock a resident who was crying by rubbing her own eyes and making crying noises and stating "there's nothing wrong with you, stop crying." LPN #3 has witnessed the Unit Manager speak rudely to family members. The LPN indicated the Unit Manager was bossy, disrespectful, and demeaning. Interview with the Administrator on 6/1/11 at 2:45 p.m., indicated she had interviewed the fifth floor nursing staff. She indicated that she was unaware of LPN #3's allegations prior to the incident. She indicated LPN #3 should have reported her allegations to the Director of Nursing or herself immediately after witnessing those events. 2. Review of the employee records on 6/1/11 indicated no pre-employment screening references		In-Service Education Program, on a quarterly basis topics such as Facility Abuse Prevention Program, Resident Rights, Managing Difficult Situations, Managing Employee Stress and Burn out, to name a few, are presented. The facility is committed to ensuring appropriate corrective action, in the future, for any staff member who fails to report possible abuse in a timely manner. Additionally, the facility offers that upon hire all new staff members are presented with a full copy of and complete a detailed review of the facility Abuse Prevention Program during their General Orientation. During this review, the requirement to report allegations of abuse immediately is discussed and staff members are made aware that failure to adhere to facility Abuse Policies and Procedures may result in corrective action in the form of disciplinary action up to and including termination. The facility is committed to the on-going education of all staff and provide any additional Abuse Prevention in-servicing as deemed necessary in conjunction with the topics already scheduled on a quarterly basis. Our in-services on this topic include the expectation that possible abuse be reported immediately as well as the consequence for failure to report immediately which include corrective action in the form of disciplinary action up to and	

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	had been obtained for CNA #2 hired 4/21/11, CNA #3 hired on 4/12/11, CNA #4 on 4/12/11, and Laundry #1. Interview with the Administrator on 6/1/11 at 3:40 p.m., indicated that no references had been obtained for CNA #2, CNA #3, CNA #4, and Laundry #1. She further indicated that this issue had been identified in Quality Assurance but no process had been developed to correct this issue. At the exit interview on 6/1/11 at 4:45 p.m. with the Executive Director, Administrator, Assistant Administrator, Director of Nursing, and Assistant Director of Nursing, it was indicated that no call was made to obtain reference after 30 days as per facility policy. 3.1-13(g)(1) 3.1-28(c) 3.1-28(d)		including termination. As it relates to the completion of reference checks for new employees, the facility has modified it's existing policy on obtaining reference checks for all newly hired staff. We are committed to submitting all requests for reference checks to previous employers via fax/telephone and completing follow-up telephone calls to those employers if there has been no response after 14 days. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** As it relates to the resident identified as Resident L, upon hire and subsequently thereafter, we will utilize our In-Service Education Program as a tool to frequently remind our staff of the policies and procedures relative to reporting of possible resident abuse and will include the consequences for failure to report such possible abuse in a timely manner. As it relates to the completion of reference checks for new employees, through the Human Resource Quality Assurance Program, the facility Administrator/or Designee will be responsible for auditing a sample of 100% of all newly hired staff to ensure the presence of a reference check. The findings will be reported to the Quality Assurance Committee on a	

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			quarterly basis. **5. By what date the systematic changes will be completed?** July 1, 2011	
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility followed its abuse policy regarding reporting all allegations of abuse immediately to the Administrator or Director of Nursing for 1 of 3 allegations of abuse reviewed, as well as obtaining references for 4 of 5 newly hired employees in a sample of 5 newly hired employees. (Resident #L, CNA #2, CNA #3, CNA #4, and Laundry #1) Findings include: The current 5/18/10 Incident Reporting Policy provided by the Administrator indicated "It is the policy and procedure of the facility to require all employees to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the Administrator." Review of the current 5/18/10 Reference Check policy indicated "It will be the responsibility of the hiring Department Head to follow up on any requests not returned within thirty (30) days. If	F0226	**F-226** Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of Kim Rhoades, Director of Long Term Care, letter to this facility dated June 6, 2011, the facility offers the following: **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility took a number of corrective actions as a result of our original investigation into this matter. To recount those corrective actions previously communicated in our final report dated December 13, 2010, the facility conducted Stress Management and Abuse Prevention in-servicing to all staff. This in-service covered the topic of stress management as	07/01/2011

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	necessary the reference source my be contacted by telephone." Review of the current 5/18/10 Employee Screening Policy provided by the Administrator, indicated "Facility will send for two reference checks on all new employees. Reference should be from previous and/or current employers. The policy and procedure for the reference checks in set forth in HRD-123. If no written response, a call will be placed within 30 days." Review of the Memorandum dated 12/13/11 of an allegation of abuse towards residents on the fifth floor indicated the facility had received an anonymous letter indicating the Unit Manager had been abusive toward some of the residents. Review of the anonymous letter dated 11/19/10 received by the facility 11/30/10 indicated the person writing the letter was a concerned family member with family who resided on the fifth floor. The family member indicated they visit their loved one several times a week and felt obligated to inform the facility of the things they had seen and heard from the Unit Manager towards some of the residents. The family member alleged the Unit Manager was rough with the residents and pushed them down. On one		well as the expectations of reporting all possible abuse in a timely manner. As it relates to C.N.A. #2, C.N.A. #3, C.N.A. #4, and Laundry #1, the facility has completed reference checks and they are currently in place in the identified staff member's personnel files. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** As it relates to the resident identified as Resident L, the facility takes a very strong position with regard to timely reporting of possible abuse. The facility will, in the future, provide appropriate corrective action (including discipline if deemed appropriate) for any staff member who does not report possible abuse in a timely manner. In an effort to offer additional corrective action as a part of this plan of correction, the facility will present follow-up in-servicing on the topic of Stress Management and Abuse Prevention in-servicing to all staff which will include requirements for timely reporting of possible abuse. As it relates to the completion of reference checks for new employees, the facility is committed to reviewing the personnel files of all newly hired staff in the past 120 days to verify the presence of a completed reference check. Any identified personnel files lacking a	

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	occasion they had seen her push a resident back down in their seat and say in a harsh voice, "sit your a** down." They had also heard her say to a resident she was fu***** sick and tired of a resident who was somewhat agitated and would be glad when she shut the he** up. On another occasion the family member had witnessed a CNA trying to calm a resident down and was not successful. The Unit Manager indicated that she was going to give her something that would shut her fu***** trap for the rest of her shift. Continued review of Memorandum dated 12/13/11 indicated upon receipt of the letter the Unit Manager was immediately removed from her position and was placed on administrative leave pending the outcome of the investigation. The facility was then able to speak personally to 26 family members. The facility indicated there was mostly positive feedback, but one family member verbalized the Unit Manager had a bad attitude and she was described as being insensitive. The facility also spoke to 6 professionals who routinely work with the Unit Manager on the fifth floor. The facility indicated some of the staff felt that the Unit Manager was compassionate and others felt she was not. Some staff indicated she had a "rough" way about her. Most staff felt the Unit Manager		reference check will have one completed via telephone. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** As it relates to the resident identified as Resident L, the facility will continue to provide on-going in-service education to all staff on the policies for timely reporting of possible abuse. Through our In-Service Education Program, on a quarterly basis topics such as Facility Abuse Prevention Program, Resident Rights, Managing Difficult Situations, Managing Employee Stress and Burn out, to name a few, are presented. The facility is committed to ensuring appropriate corrective action, in the future, for any staff member who fails to report possible abuse in a timely manner. Additionally, the facility offers that upon hire all new staff members are presented with a full copy of and complete a detailed review of the facility Abuse Prevention Program during their General Orientation. During this review, the requirement to report allegations of abuse immediately is discussed and staff members are made aware that failure to adhere to facility Abuse Policies and Procedures may result in corrective action in the form of disciplinary action up to and including termination. The facility is	

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	155131	A. BUILDING 00 B. WING	06/01/2011

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	became frustrated easily and that caused a negative interaction with staff but not the residents. All of the staff had indicated they had never seen the Unit Manager use profanity in front of the residents or was physically abusive towards them. Review of LPN #3's statement dated 12/1/10 regarding the Unit Manager from the fifth floor indicated the LPN had worked three days a week and had the occasion to work with the Unit Manager. She indicated there had been occasions when the Unit Manager had been potentially abusive towards a resident. LPN #3 had observed poor interactions with Resident #L and that the Unit Manager had been forceful in making Resident L sit down when standing. LPN #3 had also observed the Unit Manager mock a resident who was crying by rubbing her own eyes and making crying noises and stating "there's nothing wrong with you, stop crying." LPN #3 has witnessed the Unit Manager speak rudely to family members. The LPN indicated the Unit Manager was bossy, disrespectful, and demeaning. Interview with the Administrator on 6/1/11 at 2:45 p.m., indicated she had interviewed the fifth floor nursing staff. She indicated that she was unaware of LPN #3's allegations prior to the incident.		committed to the on-going education of all staff and provide any additional Abuse Prevention in-servicing as deemed necessary in conjunction with the topics already scheduled on a quarterly basis. Our in-services on this topic include the expectation that possible abuse be reported immediately as well as the consequence for failure to report immediately which include corrective action in the form of disciplinary action up to and including termination.As it relates to the completion of reference checks for new employees, the facility has modified it's existing policy on obtaining reference checks for all newly hired staff. We are committed to submitting all requests for reference checks to previous employers via fax/telephone and completing follow-up telephone calls to those employers if there has been no response after 14 days. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** As it relates to the resident identified as Resident L, upon hire and subsequently thereafter, we will utilize our In-Service Education Program as a tool to frequently remind our staff of the policies and procedures relative to reporting of possible resident abuse and will include the consequences for failure to report	

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	She indicated LPN #3 should have reported her allegations to the Director of Nursing or herself immediately after witnessing those events. 2. Review of the employee records on 6/1/11 indicated no pre-employment screening references had been obtained for CNA #2 hired 4/21/11, CNA #3 hired on 4/12/11, CNA #4 on 4/12/11, and Laundry #1. Interview with the Administrator on 6/1/11 at 3:40 p.m., indicated that no references had been obtained for CNA #2, CNA #3, CNA #4, and Laundry #1. She further indicated that this issue had been identified in Quality Assurance but no process had been developed to correct this issue. At the exit interview on 6/1/11 at 4:45 p.m. with the Executive Director, Administrator, Assistant Administrator, Director of Nursing, and Assistant Director of Nursing, it was indicated that no call was made to obtain reference after 30 days as per facility policy. 3.1-28(a)		such possible abuse in a timely manner. As it relates to the completion of reference checks for new employees, through the Human Resource Quality Assurance Program, the facility Administrator/or Designee will be responsible for auditing a sample of 100% of all newly hired staff to ensure the presence of a reference check. The findings will be reported to the Quality Assurance Committee on a quarterly basis. **5. By what date the systematic changes will be completed?** July 1, 2011	

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to supervisor resident for 1 of 1 resident reviewed for falls in a sample of 11 related to staff being unaware that during a fire pump test the doors are unlocked, staff not monitoring unlocked doors and resident going through unlocked door and falling down the stairs. (Resident #C) Findings include: The record for Resident #C was reviewed on 6/1/11 at 11:20 a.m. The resident's diagnoses included, but was not limited to, dementia, hypertension, dysphasia, cerebrovascular accident (stroke), Parkinson's Disease, and anxiety. A nursing note dated 12/1/10 at 5:00 p.m., indicate the resident was up in a wheelchair self propelling in hallway and into other resident's rooms. The resident was redirected with no success. The resident indicated she had the right to be in that room. The resident tries the exit doors when going up and down the halls. The resident was alert and verbally responsive with confusion. At 7:05 p.m. the resident was at the nurse's station. At	F0323	**F-323** Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction. In direct response to the five questions listed on page one of Kim Rhoades, Director of Long Term Care, letter to this facility dated June 6, 2011, the facility offers the following: 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** With regard to the resident identified as Resident C, the facility immediately commenced an investigation at the time of incident. Additionally, this matter was reported to the Indiana State Department of Health in	07/01/2011

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	7:50 p.m. Resident #M was observed looking through the window on the exit door. Resident #M called to the nurse and pointed down the hall. Resident #M led the nurse to the exit door and looked through the window. The nurse looked through the window and saw Resident #C lying on her back, on the landing with half of the wheelchair on the resident's body. Resident #C was alert, oriented, and answered questions appropriately. Resident #C was lying on her back with head slightly off floor resting on the wall. There was blood no the landing and Resident #C's right arm was in between the spokes of the wheelchair. 911 was called. A nursing note dated 12/2/10 at 6:00 a.m., indicated resident was admitted to the hospital for observation only. At 1:55 p.m. the resident returned to the facility. The resident was alert, oriented and able to move all extremities. The resident had an abrasion to her forehead measuring 1 cm (centimeter) by 2 cm with a scab. There was a bruise noted to the resident's forehead, purple in color and measuring 4 cm by 7 cm. The resident's right elbow had a purple bruise measuring 8 cm by 4 cm. She had edema to her right elbow. The resident did not complain of pain or discomfort.		accordance with Indiana State Department of Health guidelines for Reportable Occurrences and facility policies and procedures. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** As a result of this incident, the facility reviewed and revised it's policies for monitoring all exits on the 5th floor unit during Fire Pump Testing. All staff were in-serviced as part of our corrective action plan which was implemented at the time of the occurrence. It is the policy of this facility to notify 5th floor staff prior to scheduled Fire Pump Testing of plans to initiate such testing to ensure that staff provide necessary monitoring of exits. This incident occurred nearly six months ago and our corrective action thus far, we feel, has been successful. We are committed, however, to providing a remedial in-service on this procedure to all staff as a part of this plan of correction. 3. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?**	

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	A nursing note dated 12/3/10 at 3:00 p.m., indicated a late entry for 12/2/10 at 1:55 p.m. The resident had an abrasion with scabs to her first, second and third left finger knuckles. A Reportable Occurrence was provided by the Administrator and the Assistant Administrator and reviewed on 6/1/11 at 12:30 P.M. "On 12/1/10 at approximately 7:53 p.m., (Resident #C's name) was identified to be found on the landing of the south stair well on the 5th floor. (Resident #C's name had fallen from her wheelchair down ten (10) stairs and was noted to be bleeding." "Upon obtaining statements and investigating the cause of this unfortunate occurrence, it was determined that approximately 6:54 p.m., a routine fire pump test was commenced which disables the locking mechanisms on the stair well doors as part of our safety procedures. Our investigation determined doors were unlocked for a period of twelve (12) minutes which was the duration of the fire pump test. The facility has contacted our alarm company to confirm the times of the disabling of the locked doors and confirmed this occurrence. It is probable that (Resident #C's) exited through the stair well door during this period of time and fell."		In addition to the corrective actions initially taken in December of 2010, the facility will present in-servicing to all staff on the topic of monitoring of exits on the 5th floor during periods of disarmament of our magnetic locking system (i.e., Scheduled Fire Pump Testing, scheduled and non-scheduled fire drills, etc.). The in-service will include our policy that prior to any scheduled Fire Pump Testing being performed that the 5th floor nursing staff will be notified of plans to engage testing so that staff are aware of need for monitoring of exit. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** In collaboration with the 5th floor Nursing Unit Director, the Building Manager will be responsible for the monitoring and evaluation of the response on 5th floor during Fire Pump Testing to ensure compliance with policy and procedure. The Building Manager and/or 5th Floor Nursing Unit Director shall report any lapses in adherence with policy and procedure to facility Administration.	

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	"The facility has met this morning to discuss preventative measures for the future. During a normal fire drill, the facility has now put in place a procedure to monitor all exits on the 5th floor locked unit during the weekly fire pump test as an additional precaution." Interview with the Assistant Administrator on 6/1/11 at 2:35 p.m., indicated that prior to running a fire pump test an announcement was made over the intercom system. On 12/1/10 the announcement was made prior to the test, however it was the first time the test was ran during the 3-11 shift. She indicated the fire pump test was ran weekly and on Wednesday. Staff realized the test had not been completed on 12/1/10 during the day so the test was ran on the 3-11 shift. The Assistant Administrator further indicated the staff on the day shift was aware that the doors were unlocked during this test and would know to monitor the doors. The staff working the 3-11 shift were unaware the doors would be unlocked and therefore unaware that they needed to monitor the doors during the test. 3.1-45(a)(2)		5. **By what date the systematic changes will be completed?** July 1, 2011	